Commonwealth of Virginia DMHMRSAS

The Partnership Press

Restructuring the Services System Through Regional Partnership Planning

Mark R. Warner
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Commissioner

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A Message from the Commissioner

"If we have bed crisis or shortage in the Commonwealth, why are we closing mental health beds…am I missing something?"

I hear that question occasionally from stakeholders in our system. It is an understandable question. On the surface it doesn't make sense.

But here is what I think people are missing who ask that question:

- The bed shortage now means we have to do something different. We can't stand still. There has been no new money identified for new beds. So building new beds is not an option.
- At any given time there is a finite amount of resources to provide inpatient and community services in our system.
- We do not currently have adequate resources in all parts of our communities to consistently provide least restrictive, most appropriate community based services.
- There continue to be a variety of ways we are utilizing the beds we have in our mental health facilities. For example, there are significant differences in lengths of stay in the psychiatric facilities.
- We know we will always need the safety net of state operated mental health beds, but we do not know exactly what that ideal number of beds is until we maximize the utilization review of those beds.
- The best, most effective and most efficient utilization of our valuable mental health facility beds is accomplished by "joint ownership and review of those beds".
- "Joint ownership" means facility and CSB staff together performing utilization review of the timely admission and discharge of each patient so that not one bed day is wasted.
- "Joint ownership" and utilization review of the mental health beds in our state facilities and in the private community beds that are purchased with state funds will enable just as many (or more) people to be served in the inpatient beds (through decreased lengths of stay). Reinvested facility resources (derived from the closure of some, obviously not all, of those beds) can then be used to create additional community service capacity.

Inside this issue:

In other words, closing some of our current beds as the reinvestment projects are doing only makes sense if we can serve just as many or more people in those beds or in state purchased beds and also reinvest dollars to create new community services, such as crisis stabilization units, more PACT teams, etc. Region IV has been demonstrating for some time now that this is precisely what can happen.

The reinvestment projects at Eastern, Central and Western State Hospitals are only a sample of the ways that the system is moving toward "One Community" – to borrow the name of the draft final Olmstead report for Virginia. Seven Regions are planning ways to move the system to one community through partnership planning projects that you will read about in this issue. The system is tackling not only the changes needed in Mental Health but in all of the other populations and services that we provide. Thank you for your interest and participation in these exciting changes, even during difficult times with major challenges.

James S. Reinhard, M.D.

Regional Updates*

**Note: These regional updates are based on the presentations given by each region at the May 15th Stakeholders Forum in Richmond. For the most current regional activities, please contact the regional leadership for each area. Regional leadership contact information may be found on page 8.*

Central Region

Regional Activities: Implementation of the Central Region's reinvestment plan will begin July 1st. Through the RFP contracting process, a regional 24/7 supervised residential, dual diagnosis, crisis stabilization/detoxification service will be established for the region. In addition, regional specialized nursing home beds will be available on a purchase-of-service basis. By July 2003, the Central Region plans for ten to fifteen discharges, which will allow for the closure of one civil unit at CSH. Another ten to fifteen discharges are expected by October 2003, allowing a second civil unit to close at CSH. The region will also be hiring a Project Manager, establishing a utilization review system and strengthening the CSH census management process. While there may be some shifting of personnel resources at CSH, there are no anticipated lay-offs and reinvestment personnel objectives will be met through the use of vacancies and attrition.

Eastern Region

Regional Activities: The Eastern Region plan focuses on the carefully phased-in closure of acute care services at Eastern State Hospital (ESH). The current acute care admissions unit has 86 beds. Approximately half (43) of those are used for acute, short-term care, with the balance serving individuals with long-term care needs. Phase I of the project will result in the closure of 43 beds and will be modeled after the Region IV Acute Care Project in the Richmond area, where the region successfully provided acute psychiatric inpatient care in the community to many more consumers than were previously served at Central State Hospital, and at much lower cost. Phase II will focus on the closure of an additional 43 beds serving longer-term patients. The Eastern Region has identified guiding principles for use in implementing the plan that may be helpful for other regions. Their goals reflect those guiding principles to ensure that core mental health services and supports:

- Are provided within a comprehensive continuum of services designed to meet consumer and family needs and based on best practices;
- Are well integrated with the broader continuum of care provided by health and social services;
- Are organized and coordinated based on a "levels of need" structure to ensure that consumers have access to services that best meet their needs;
- Are appropriately linked to other services and supports within the geographic area
- Facilitate a shared service approach to meeting the needs of consumers with serious mental illness who have co-occurring disorders and multiple service needs;
- Achieve a clear system/service responsibility and accountability through the development of standardized operational goals and performance indicators; and
- Are simplified and readily accessible, according to the needs of consumers and their families.

Northwestern Area

Regional Activities: The Northwestern Region is scheduled to begin individualized discharges in July '03. A six-bed intermediate care facility for persons with mental retardation (ICF/MR) will provide services to individuals discharged under this plan. In addition, the region is working on individualized treatment plans for approximately 40 individuals, some of whom are dually diagnosed. Thirty-nine wrap-around plans have been approved at an average cost of $44,000 per person per year. More plans are being submitted for review. Some bridge funding will be maintained for acute care bed purchase, while other bridge funding will be used for discharge start-ups and development of an infrastructure. As a result, the Northwestern Region plans to close two units at WSH. It is likely that most affected staff positions will be absorbed through vacancies and attrition. Some staff may be deployed temporarily to the community. However, significant changes to the staffing of Western State Hospital are not expected.

Regional Updates (cont'd)

Southern Region

Regional Activities: The Southside, Danville-Pittsylvania, and Piedmont CSBs are soliciting input from stakeholders and are sponsoring a Regional Stakeholders' meeting on July 24th in Danville at Danville-Pittsylvania Community Services. In June, Southern Virginia Mental Health Institute will hold consumer and family meetings throughout the region. Stakeholders will be encouraged to participate in at least one meeting in each CSB catchment area. Information gathered as a result of these meetings will be used to craft an August 1st report outlining the MH/MR/SA needs in the region.

Northern Region

www.fairfaxcounty.gov/service/csb/region/partnershipmain.htm

Regional Activities: The Northern Region has a target date of 2005, allowing the region to integrate reinvestment plans into its overall restructuring process. A steering committee was formed last December that developed a vision statement and guiding principles and also conducted fourteen public forums and consumer focus groups throughout the region. Additionally, three workgroups have been developed: a mental health workgroup, a structural workgroup and a private hospital workgroup. The mental health workgroup has explored the enhancement of crisis care beds (as step-down beds), vocational services, peer support, increased service flexibility and facilitation of community integration for the NGRI population. A tool to assess Levels of Inpatient Treatment Need was developed and has been used to document patient profiles at Northern Virginia Mental Health Institute and the inpatient psychiatric units at the regional private hospitals. There have also been efforts directed to updating current psychiatric bed capacity in the private sector and identification of potential systems barriers that may impact inpatient services. The structural workgroup is exploring areas of regional collaboration, such as training, quality improvement and information technology. Regional needs and challenges have focused on housing, transportation, employment and medication costs. Two major challenges for the Northern Region are bed access/availability and limited capability to serve at-risk populations in the private sector.

Catawba Region

Regional Activities: The goal of the Catawba Region is to develop a single, seamless system of care that maximizes the resources available in the existing systems of care. This proposed single system would include shared physician capacity, joint PACT teams, joint treatment programs for special populations, treatment services designed for individuals with Axis II disorders, centralized pharmacy services and PSR services in the hospital. Leadership for the region was established in March and workgroups have been developed to create a shared vision, determine the feasibility of each element of the original proposal, "blend" systems already in place and share resources to expand the system and improve quality and efficiency. The workgroups will also address issues beyond the current resource availability, which include transitional housing, respite care, employment, and staff training and education.

Far Southwestern Region

Regional Activities: The Far Southwestern Region plan has been called a "natural" extension of the existing Southwestern Virginia Behavioral Health Board, which includes the Southwestern Virginia Consumer and Family Involvement Project (CFIP). The Southwestern Virginia CFIP is helping to coordinate stakeholder input. Plans are to hold a series of meetings across the region this summer to allow broad stakeholder involvement in and reaction to planning efforts. It is anticipated that bridge funding will be utilized in fiscal year 2004 for the purchase of private, acute care beds to divert admissions from Southwestern Virginia Mental Health Institute. In addition, a regional program will be developed to serve individuals with dual diagnoses (MR/MI) who are considered difficult-to-manage.

Employment Q&A

What happens to me if my position is eliminated as part of the reinvestment project?

DMHMRSAS is required by the fiscal year 2004 budget bill to have a transition plan in place for any affected position. We will first look for vacancies in the facility in which you are currently employed. If there are no vacancies, we will look at placement in another DMHMRSAS facility or another state agency. Currently, facilities are holding as many vacancies as they can to use as placement opportunities for employees. Also, where possible, we are not filling vacant positions in unit(s) to be closed, or we may be temporarily filling in vacancies with other classified staff, wage employees or contract employees. We will also be looking for placement opportunities with local private providers and Community Service Boards (CSBs). Some employees may be temporarily loaned to work for private providers or CSBs.

How will I know whether there is a vacant position I can move into at the facility?

The transition plan will identify immediate vacancies and you will be notified at the time of its implementation as to what your placement options are. If placement options are outside of the facility, we will work with you to try and find an option that works best for you.

Will I have to compete for positions at other state agencies?

If you are in an affected position you may want to independently look for positions at other agencies. In this instance you would need to compete for any positions you are considering.

As part of our transition planning, if we cannot immediately find positions to place affected employees, one of our strategies will be to work with other state agencies in your locale in order to identify vacancies for which you and others may be qualified. We will be looking for positions into which you may be transferred without competition.

What does it mean to be loaned to a private provider or CSB, and how will it affect me?

There may not be enough immediate vacancies at a facility to absorb all the employees affected by the reinvestment project. If a local private provider or CSB has a need for employees for the service being transferred to them or for other services, the facility may temporarily place employees with them until a vacancy occurs at the facility for which the employee is qualified. In this way we may help the community service provider while retaining employees in the state service.

If I am "loaned out" to a private provider or CSB what happens to my pay and state benefits?

They remain the same. You will continue to be a state employee with the same salary and benefits.

How long might I be on loan?

We do not plan on having anyone on loan for more than a year. Given our turnover rates we believe that a vacancy that is a good match for you should come open in that time.

What is the significance of the July 1, 2003 date?

Reinvestment bridge funding is being held in an escrow account so that on July 1, 2003 this funding will be available to help bridge the transition from previously provided facility services to fund services within community settings. Funding will be distributed as regional plans are evaluated and services are approved for funding.

How can I give input to and impact the plan under development in my region?

You may share your ideas and suggestions with managers who are within your supervisory/leadership structure. They will ensure that the Facility Director receives your suggestions. Facility Directors at CSH, ESH and WSH are co-chairs for the regional reinvestment planning projects along with a local CSB Executive Director who is also a co-chair. Further, each of these facilities will provide open forums to share information with employees periodically. This will be another opportunity to provide input.

Every attempt will be made to keep you informed of the progress being made on these projects. If at any time you have questions about the project and its impact on your job, please contact your facility Human Resource Office.

REINVESTMENT Q&A

In the past few months there have been reports of patient abuse, mismanagement, and failure to meet state standards at local private care facilities. What will prevent more cases of this type of problem as the projects are implemented?

Prevention of all problems is probably not possible anywhere. Providers are expected to meet licensing and human rights standards, and they are reviewed annually through unannounced visits and more often when there are complaints. They are required to report serious injuries, deaths, and abuse and neglect. These requirements are intended to increase scrutiny, raise standards, and at times do prevent problems. The Office of Licensing places priority on responding to incidents quickly once they become known to avoid additional problems. Because oversight agencies have limited resources and cannot be in programs as frequently as might be needed, it is imperative when a service provider working with one of these community facilities has concerns about the care and treatment, that those concerns are reported to the appropriate oversight agency to address. The service provider should address those issues directly with the facility. Ensuring client safety and appropriate care has to be a cooperative effort for all involved.

How will the specific projects save money when they are reducing less-costly beds in state hospitals and more patients will be sent to more-costly, private and for-profit hospitals?

Reinvestment projects are not primarily aimed toward saving money; while saving money is one goal, the primary goal is to shift care from inpatient settings to community-based settings. While the per day cost of private acute psychiatric hospital beds is usually more expensive than state hospital acute care beds, the length-of-stay is usually significantly shorter, thus substantially reducing the overall cost of care for individual treatment episodes. In addition, the projects are working to identify intermediate-level of intensity services that will fill a current gap between the inpatient level of care and traditional outpatient-focused community level of care to ensure successful discharge for patients from the private hospitals to community programs.

Wouldn't it make more sense and be more efficient/easier to reduce the average length-of-stay for patients in state hospitals than to outsource or downsize beds?

If the primary goal of the reinvestment projects was to save money and reduce budgets, it might be easier to simply reduce the average length-of-stay across the state. However, the reinvestment projects seek to fundamentally shift mental health treatment and align Virginia with national trends towards increased community-based care. The downsizing of beds will free funds for reinvestment into additional community-based services that will prevent unnecessary hospitalization by providing a comprehensive array of services.

Why are certain regions using reinvestment to plan for the purchase of beds in private hospitals instead of developing community programs for patients who are currently discharge ready but still in state hospitals?

Some reinvestment funds will be used to purchase acute care beds in private hospitals. The hospitals may, in fact, be closer in proximity, to an individual's home and family. The safety net of state hospitals will not disappear; however, the shift in funds will focus on treating most individuals within their communities and reserving state hospital beds for individuals with long-term treatment needs that cannot be met in community settings. At the same time, the projects will also be addressing the need for additional community treatment services to be able to serve individuals who are currently receiving services in state hospitals but who are ready for discharge. Among the various service needs being examined are housing, ICF/MRs, employment, consumer education and family involvement. Also, at least one of the reinvestment projects proposes discharging some long-term patients using the Discharge Assistance Project (DAP) approach of funding the complete costs of the person's care in the community. The DAP has been phenomenally successful in discharging long-term patients permanently to the community, with very few (less than 5 percent) returning to a state hospital.

REINVESTMENT Q&A (Continued)

Who will provide treatment for the most "difficult to manage" population?

The Supreme Court Olmstead decision states that states must make reasonable efforts to assist individuals with disabilities who are ready to be discharged and who choose to be discharged to a community setting to be served in the least restrictive environment possible. Virginia's Olmstead Plan is currently being developed and finalized for presentation to the Governor and the General Assembly. In responding to the Olmstead decision and in shifting more of Virginia's treatment focus to the community, a broad array of services will need to exist to support a variety of needs in each community. The specific reinvestment projects will address the needed array of services. For individuals who need more intensive and longer-term treatment than is available in communities, state hospitals will remain an option.

How will the state/regions ensure adequate services to individuals who are homeless? What is being done to provide adequate community supports and shelter services to this population upon discharge?

The reinvestment projects cannot meet all of the unmet demand for services. There will continue to be unmet service needs, including those for homeless people with mental disabilities. These projects will bring these needs to the forefront, however, so that the public and policy-makers will be aware of this problem. It is important to note that HUD policies require the identification of housing supports in discharge plans from state facilities. All individuals discharged from state facilities participate in discharge planning that identifies such housing supports prior to being discharged.

Will the reinvestment projects ensure services for the forensic population? What about people with mental illness who are currently incarcerated?

The regional work groups have begun to address the potential for using community reinvestment resources for providing improved mental health and substance abuse services to consumers with criminal justice system involvement. HPR IV (the Richmond region), for instance is considering the implementation of a community-based diversion model for addressing the treatment needs of their forensic patients.

In addition, special teams are being formed in the next month to address the needs of certain special populations, including forensic/jail services. It is anticipated that these teams will work in concert with an existing legislative study group (SJR97) and community representatives to stimulate efforts to improve services for mentally ill and substance abusing offenders in the community, and in jail settings.

How will each phase of the reinvestment projects be monitored? How will quality of care issues be addressed?

Quality will be monitored at the statewide and regional levels. The Regional Leadership teams will develop and include specific indicators and procedures for measuring and monitoring quality locally. Although the actual details have not been finalized, the Regional Leadership teams and their members are key to the development and interpretation of these measures. Included among the Regional indicators will be a core of quality indicators that a team including the DMHMRSAS, VACSB and the Regional Leadership will collect and the DMHMRSAS will report to the Legislature on a quarterly basis. Through this process, the quality of care can be monitored at local, program, and statewide levels. Services that are provided by licensed providers in the community will be monitored through the normal licensing review process. Complaints about these services can be made to the Offices of Licensing or Human Rights.

Commission on Youth Publication

In recognition of May as National Mental Health Month, the Commission on Youth announced a new effort to increase awareness of children's mental health issues. "With the increase in attention given to children's mental health and the development of treatments for children with serious emotional disorders, mental health is emerging as a new focus in the field of early childhood development" stated Delegate Phillip Hamilton, Chairman of the Commission on Youth. "Family members, practitioners, and researchers are becoming increasingly aware that mental health services are an important and necessary service for young children who experience mental, emotional, or behavioral challenges."

In 2002, the General Assembly directed the Commission on Youth to coordinate the collection of evidence-based treatment practices recognized as effective for the treatment of children with mental health disorders. Advisory groups of mental health experts were established to assist in the effort. This resource, **Child and Adolescent Mental Health Treatments**, was published in late 2002 and posted on the Commission on Youth website. It can be accessed at coy.state.va.us. The link is:

http://coy.state.va.us/Modalities/contents.htm

Child and Adolescent Mental Health Treatments is tailored for parents, caregivers, educators, service providers and others seeking current research on evidence-based treatments. The Collection includes sections on: mental retardation, pervasive developmental disorder, behavior disorder, maladaptive behaviors, Tourette's disorder, anxiety disorders, mood disorders, schizophrenia, substance abuse and mental illness, youth suicide, school-based services, juvenile offenders and helpful resources (example: frequently used terms).

To ensure that this information gets to its intended audience, the 2003 General Assembly passed Senate Joint Resolution 358, patroned by Senator Edward Houck. This legislation requires the Commission to disseminate **Child and Adolescent Mental Health Treatments**. Executive branch agencies, local agencies, health organizations, health providers and advocacy groups are partnering with the Commission in this effort so that as many individuals as is possible across the Commonwealth can access this resource. "Dissemination of this resource is important in promoting the use of evidence-based treatments and ensuring that children receive the appropriate treatment," stated Amy Atkinson, Executive Director for the Virginia Commission on Youth. The Commission on Youth recognized their partners in this effort and officially launched the Child and Adolescent Mental Health Treatments website on May 19th.

Upcoming Regional Meetings*

NORTHWESTERN REGION:
Regional Partnership Meeting
July 18th in Culpepper

SOUTHERN REGION:
Regional Stakeholders' Meeting
July 24th
Danville-Pittsylvania Community Services

NORTHERN REGION:
Steering Committee Meeting
June 26th
Fairfax County Government Center

**Note: Additional meetings may be scheduled for each region. Please contact the regional leadership to inquire about additional meetings, locations and times.* *Regional leadership contact information may be found on page 8.*

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